HARFORD COUNTY PUBLIC SCHOOLS
BOUNDARY EXCEPTION APPLICATION

Student’s Name ___________________________________________ Birthdate __________________
Student ID Number (if known)__________________________ Gender (M or F) _____ Grade applying for ______
Sibling with boundary exception (yes) _____ If yes, name ____________________________ (no) ______
Applicant ___________________________ Relationship to Student ___________________________
Applicant must be an adult legally recognized as responsible for the student (i.e. parent, caretaker, foster parent).
Complete Address ____________________________________________ (include city and zip code)
If the above address is different from the one that the school currently has in your child’s record, an updated proof of residency must be submitted (e.g. BGE statement showing the above address) along with this application.

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>Email</th>
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Home School __________________________ Requested School __________________________
Requested School Year __________________________

Reason: (please check primary reason)
_____ A. Child Care (complete reverse side) _____ D. Child of HCPS Employee
_____ B. Curriculum (program of study for high school) _____ E. Moved during current school year
_____ C. Hardship (documentation required) _____ F. Continuity for completing grades 5, 8, & 12

*Applications for kindergarten students will not be considered until after July 1 and require student to be enrolled in his/her home school prior to application being considered.

Please describe the reason why you are requesting to enroll your child in a school other than the home school. Please attach any pertinent information from other agencies or individuals that support your child’s need for this boundary exception.
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

PLACE OF EMPLOYMENT

Name of Parent/Guardian 1: ________________________________
Place of work ___________________________________________ Hours __________________
Address __________________________________________________ Telephone ______________
HCPS employee ID number ________________________________ (if applicable)

Name of Parent/Guardian 2: ________________________________
Place of work ___________________________________________ Hours __________________
Address __________________________________________________ Telephone ______________
HCPS employee ID number ________________________________ (if applicable)

Applicant, if not Mother/Father:
Place of work ___________________________________________ Hours __________________
Address __________________________________________________ Telephone ______________
HCPS employee ID number ________________________________ (if applicable)

PLEASE COMPLETE REVERSE SIDE OF FORM
CHILD CARE PROVIDER VERIFICATION  
(TO BE COMPLETED BY PROVIDER)

Name of Provider or Facility ___________________________________________________________________________
Address ____________________________________________________________________________________________ Telephone _________________________
___________________________________________________________________________________________________________
(Name of Child) receives child care services on ___________________ at ___________________.
(Days of the Week) (Times)
Signature of Provider ____________________________________________________________________________
Date ____________________________________________________________________________________________ Relationship to Child ____________________________________________________________________________
NOTE: A Pupil Personnel Worker will call the Provider or Facility to verify the child care information as stated above is accurate.

By signing this application, I attest the above information is true and accurate. *If it is determined that information
has been falsified the boundary exception will be revoked immediately.

__________________________________________________________________________
Applicant's Signature Date ____________________________________________________________________________

If any of the conditions or circumstances on this application change, you MUST immediately notify the Pupil Services Office below:

EDGECWOOD PUPIL SERVICES OFFICE
ATTN: CRAIG MALONE & LISA SAUER
2311 WILLOUGHBY BEACH ROAD
EDGECWOOD, MD  21040
410-612-1521

The deadline for applications is June 1

For Office Use Only
PPW  ☐Approved  ☐Denied  ☐Deferred
Receiving School Principal  ☐Approved  ☐Denied  ☐Deferred Date: ____________________________

Rev 12/13/19